Preliminary Draft

Primary Care Chapter

District of Columbia State Health Systems Plan

State Health Planning and Development Agency
District of Columbia Department of Health

PRIMARY CARE SERVICES
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PRIMARY CARE SERVICES

I. INTRODUCTION

Access to primary and specialty care is vital to maintaining the health of a community. Primary care serves as a gateway to a variety of preventive and specialty health services. A good primary care model includes diagnosing diseases in time to preserve the quality and length of life and informing patients on wellness. Additionally, in primary care settings, many patients learn about healthy lifestyles. Providers educate patients on healthy eating habits, the role of nutrition and physical activity in reducing chronic diseases. They inform patients about the negative effects of substance abuse, smoking, and unsafe sexual behaviors. To the extent that patients engage as partners with their primary care providers, they are able to learn to successfully self-manage or avert potentially life-threatening conditions such as heart disease, diabetes, asthma, hypertension, or HIV/AIDS.

II. DEFINITION AND CHARACTERISTICS

Primary care is usually the first contact of care where health assessments are made and general medical care is provided, such as well baby care, prenatal care, dental care and mental health services. According to the American Academy of Family Physicians (AAFP), the domain of primary care includes the primary care physician, who is often a family physician or doctor trained as a general practitioner. Also included are other physicians who may provide some aspects of primary care in their practice, nurse practitioners and physician assistants. Primary care physicians are specifically trained to handle initial visits and continuing care for individuals with undiagnosed health concerns. These physicians often serve as gatekeeper and collaborate with other health professionals and specialists, generating referrals and consultations whenever appropriate.

Primary care practices are often located within the community, which facilitates access to health care. It is important to ensure that high quality services are accessible, affordable, and culturally competent to all patients regardless of their ability to pay.

The delivery of primary care services is routinely provided in ambulatory care settings, including physician offices and hospital outpatient clinics and independent community health centers. Ambulatory Care is defined as health care services that are delivered on an outpatient basis, where an overnight stay is not required. Some of the services that are provided in the ambulatory care setting include screening and treatment for asthma, hypertension, cancer, diabetes, and rehabilitative services. When appropriate, referrals are made for additional follow-up. Maternal and child health care services are also commonly provided in an outpatient setting. Some surgical procedures may also be performed in an ambulatory care setting.

Much of the health care that is provided to the medically vulnerable population is delivered through a network of clinics and private physician's office in the District. These at-risk populations often require a complex integration of different services other than just medical care. Enabling services, such as, transportation, interpretation/translation and other supportive services are sometimes as important as medical and surgical specialty care. In outpatient settings, these services along with case management, and other social work services are needed to ensure that patients obtain optimal primary care.

III. BACKGROUND AND TRENDS

A. History

Historically, the District of Columbia government has operated a network of public health clinics or community health centers, as well as much of the ambulatory care provided to the uninsured. D.C. General Hospital was the public hospital that provided the largest proportion of uncompensated inpatient care in the District. Medical, surgical, and dental care was provided to the uninsured, as well as some primary care including obstetrics and gynecological services. Pediatrics, and internal medicine were also provided by D.C. General Hospital clinics. Other hospitals in the area also provided dental services to District residents, regardless of their ability to pay.

In the 1970s, freestanding charitable clinics, often staffed by volunteers, began to emerge to help provide services to special populations. By the year 2000, 13 providers had 27 free clinic sites in a single network. Unity Health Care was the largest single provider in the District of Columbia receiving federal 330 funding for primary care operations.

In 1996, legislation was passed to form the Public Benefit Corporation (PBC), a quasi-governmental agency of the D.C. Government. The PBC was charged with delivering care to under- and uninsured District residents. In 1997, the District of Columbia transferred the personnel and facilities of D.C. General Hospital and 14 public health clinics to the PBC with the intention of creating a more efficient and effective, fully integrated safety net health care delivery system. Eight community health centers survived the initial transition to the PBC; by 2001, six today remain.

D.C. General Hospital was closed in 2001 and the D.C General clinic and the remaining hospital services were privatized. Care to the uninsured population was transferred from the PBC to a group of health care providers who formed the D.C. Health Care Alliance (Alliance). The Alliance consists of primarily of Greater Southeast Community Hospital, Chartered Health Plan, a local Medicaid Health Maintenance Organization (HMO), Unity Health Care Inc., and the Non-Profit Clinic Consortium (NPCC). The contract between the District of Columbia and the Alliance is being administered by the Department of Health, which also monitors the accessibility, availability and quality of care under privatization through the Health Care Safety Net Administration (HCSNA).

Prior to the development of the Alliance, the PBC had delivered more than one-third of the primary care services and more than 90 percent of the specialty care services provided by all safety net providers. According to a September 2000 analysis by the D.C. Primary Care Association (DCPCA, 2000), the PBC's community health centers provided 117,795 primary care visits out of a total of 308,138 primary care visits (38.2 percent)[1] furnished by the safety net primary care facilities for the most recent 12-month period for which information was available. The remaining two-thirds of primary care services was being provided by Unity Health Care, Inc. and the 12 other freestanding clinics that form the Non Profit Clinic Consortium (NPCC).

In fiscal year 2000, the Ambulatory Care Center at D.C. General Hospital provided 23,200 medical subspecialty visits and 33,725 surgical subspecialty visits.[2] D.C. General also provided 9,017 OB/GYN visits and 16,314 dental encounters in fiscal year 2000. The total number of ambulatory encounters provided by the hospital was 98,218.

Concurrently, other historical safety net providers remain in operation, including the members of the Non-Profit Clinic Consortium (NPCC), which was formed in 1997 to represent the freestanding clinics and Unity Health Care. The NPCC members operate 27 nonprofit and free clinics, including the 14 clinics run by its largest member, Unity Health Care. The Archdiocesan Health Care Network, run by Catholic Charities, through which more than 300 physicians volunteer their services, also continues to provide services.

B. Trends in Primary Care Utilization

[1] Estimates by the D.C. Primary Care Association (DCPCA, 2000) place the percentage of the city's uninsured patients served by the PBC's six community health centers at 35.1 percent, or 20,000 of 57,000 patients receiving primary care.

[2] D.C. Health & Hospitals Public Benefit Corporation Statistical Summary-Actual by Month and YTD—FY2000.

For the past two decades there has been an increase in the use of outpatient care, including a shift to greater use of ambulatory surgery for minor procedures, such as, eye surgery and ear/nose/throat procedures. This increase has corresponded with a decrease in utilization rates for inpatient care.

In 1994, the first year for which data are available, there were 18.8 million ambulatory surgery visits in the U.S., 16.0 million of which occurred in hospitals and 2.9 million of which occurred in freestanding health centers (Kozak et al., 1997). In 1996, the latest year for which data are available, there were 20.8 million ambulatory surgery visits—an increase of nearly 11 percent (Hall & Lawrence, 1998). Increases also are apparent in recent years in the use of hospital outpatient and emergency services. In 1992, there were 56.6 million visits made to outpatient departments of non-federal, short-stay or general hospitals in the U.S., or 22.5 visits per 100 persons (NCHS, 1993a). In 1999 94.8 million such visits were made, or 31.1 per 100 persons (NCHS, 2001b).

Partly as a result of the shift to outpatient care, as well as, managed care and the availability of more effective medications, the range of occupancy rates in community hospitals fell, from close to 80 percent in 1980 to just slightly more than 60 percent in 1997. During this same time period, average length of stay declined 32 percent, from 7.3 days in 1980 to 5.0 days in 1999 (NCHS, 2001a). The rate of hospitalizations also declined—from 168 per 1,000 population in 1980 to 122 in 1990 and 116 in 1999.

Interestingly, the use of office-based physicians declined slightly between 1992 and 1999. In 1992, Americans made 762.0 million visits to nonfederal employed, office-based physicians, or 30 per 100 population (NCHS, 1993b). By 1999, this rate had fallen to 27.9 visits per 100 persons (NCHS, 2001d). Although no explanation has been offered by NCHS for this trend, it may be a function of the increasing proportion of Americans who lack insurance.

This shift away from inpatient provision of health care services began in the early 1980s when the federal Health Care Finance Administration (now known as Centers for Medicare and Medicaid Services (CMS) put into place a prospective payment system that reimbursed a fixed amount per hospital stay based on the patient's diagnosis: Diagnosis Related Groups (DRGs). With the implementation of this system, the length of hospital stays was reduced almost immediately.

Concurrently, managed care was becoming a strong market force through its use of cost-saving mechanisms, driving the integration of provider-coordinated systems of care and imposing requirements for prior authorization of inpatient admissions.

The challenge now, for the District of Columbia and other states, is to develop ways to direct and monitor the primary care sectors to ensure that population health needs are met. Over the past two decades, the trends described above have transformed the primary care sectors from a peripheral segment of the health care system to its central element.

Most states have in the past focused their planning and regulatory attention principally on institutional care.

C. The Federal Bureau of Primary Health Care's Role in Primary Care Services

Public sector primary care trends (and, to a degree, specialty care trends) are a matter of federal policy, established and implemented by the Bureau of Primary Health Care (BPHC), under the Health Resources Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). BPHC's mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations (HRSA, 2001).

Approximately 90 percent of BPHC's $1.3 billion dollar budget for fiscal year 2001 was devoted to the Community Health Center Program, which funds the 1,029 community health centers in the U.S. providing care to more than 8.3 million uninsured and underinsured Americans (NACHC, 2001; BPHC, 2001). BPHC also funds the DC Primary Care Association, the Area Health Education Center, the Department of Health Primary Care Office, and supports several grant-funded initiatives in the District.

FQHC or look-alike status is needed in order for a clinic to be eligible for Section 330 Community Health Center funding and a host of other benefits, including enhanced reimbursement, technical assistance from BPHC and eligibility to apply for grant funds.

The FQHC/Community Health Center Performance Expectations formed the basis for the Accreditation Standards now used by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) to establish standards of care for accreditation of community health centers. These standards form the basis for the criteria that is used for determining if a clinic is eligible for federal funding as a Section 330 clinic.

BPHC has specified the qualifications that a clinic must meet to become a Federally Qualified Health Center (FQHC). These qualifications are outlined in the following key principles underlying the Bureau of Primary Health Care (BPHC)'s *Comprehensive, Community-Based Health Service Delivery Mode* are:

1. The health care delivery system serves the *universal population* of the service area in order to prevent disparities of outcome, including permanent and transient individuals.
2. Interdisciplinary *community-based health care teams* address all the health needs of the population for preventive services, early diagnosis and treatment, medical, mental health, dental, and other care on an inpatient and outpatient basis as deemed appropriate by the clinical team.
3. The population being served has access to *care on demand w*hen needed and hours and locations are convenient.

4. The care occurs within a *cultural framework* appropriate to the patient.
5. Patients have a *role and responsibility* to aid and actively participate in their care.
6. Patients have the right to make *free and informed decisions* regarding treatment modalities, including the right to refuse treatment.
7. The *costs of care* are provided within achievable ranges and distributed equitably and responsibly.
8. *Performance measures*, monitored at the community level, give equal value to patient satisfaction, clinical outcomes, and functional health status and cost.

According to the BPHC's model, the only acceptable causes for failure to meet outcome measures are the limitations of current medical theory and/or the free and informed choice of a person not to access appropriate care modalities.

More freestanding community health centers are beginning to seek Federally Qualified Health Center (FQHC) status through the Bureau of Primary Health Care (BPHC). This designation would qualify the centers to receive a permanent new funding stream. Additionally, it would require that they function at a certain level of quality set by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) using national standards especially developed for ambulatory care facilities.

Clinics that are not accepted as FQHCs may still qualify as FQHC look-alikes, which entitles them to significantly higher cost-based Medicaid rates and other benefits. It should be noted that cost-based reimbursement for FQHCs and look-alikes places a financial demand on states, which are required to supply local matching funding to support these higher costs.

Financing for FQHCs has risen steadily in recent years. Given the nature and extent of its health indicators, and its many vulnerable populations, the District of Columbia is in a unique position to develop a primary care infrastructure eligible for some of this funding.

D. Challenges to Primary Care Service Delivery in the District of Columbia

1. Geographic Distribution of Primary Care Sites

The geographical distribution of both primary care services and of specialty care services is uneven throughout the District of Columbia (see Table 2). The U.S. Department of Health and Human Services, Bureau of Primary Health Care (BHPC) has designated sections of Wards 1,2,4, 6, 7 and 8 of the District as Health Professions Shortage Areas (HPSAs). Eighty-four census tracts clustered in five neighborhoods (Anacostia, Brentwood, East Capitol Street, Mt. Pleasant/Upper Cardozo and South Capitol) have been designated as HPSA shortage areas for primary medical care (Federal Register,

2000). In addition the homeless population in downtown D.C. has been designated as a Medically Underserved Population.

This designation of HPSAs shows a lack of geographic access to care in the District of Columbia's poorest neighborhoods, particularly those east of the Anacostia River, which exhibit some of the greatest primary care needs. As summarized in the D.C. Primary Care Association's recent primary care needs assessment (DCPCA, 2000a), there are 25 safety net clinics in Wards 1 and 2, and 27 are distributed among the remaining six Wards of the District.

One of the primary aims of the District's contract with the Alliance continues to be improving access to care by opening a large network of primary care providers to the uninsured and insured populations.

2. Uniform Standards of Care

The District's Medicaid managed care contract contains performance standards for Health Maintenance Organizations (HMOs). Standards have not been uniformly implemented across the outpatient care delivery system, as they do not apply to providers who do not participate in the Medicaid managed care program.

The Alliance contract contains specific performance standards for Alliance providers. Outside of the Alliance safety net, individual practitioners, medical groups, health maintenance organizations (HMOs), and outpatient clinics provide additional ambulatory and primary care in the District of Columbia. Physicians are licensed based on demonstration of appropriate professional training.

3. Continuum of Care

A more integrated and technology driven system within the primary care delivery system will improve the delivery of services. A large number of individuals believe that limited integration exists in the system.

The result of this limitation is that some services that impact continuity of care may be fragmented. In some cases this makes it difficult for providers to know if patients are receiving comprehensive, coordinated services.

4. Physical Infrastructure/Building and Equipment

Many of the District of Columbia's safety net primary care facilities are in need of renovation and equipment update.

A recent report by Capital Link, released by the DCPCA in 2001, assessed the cumulative capital needs of essential community providers at a figure of $25,165,000. This estimation does not reflect the needs of all primary care health facilities in the District of

Columbia. Responses to the study captured only those organizations with capital campaigns. Physical infrastructure needs could be one of the major impediments to providing primary care in the population served by the safety net clinics.

5. Cultural Competence of Providers

The nature and extent of provider cultural competence in the District of Columbia's safety net continues to expand and change to meet the critical needs of the diverse population. Several District of Columbia clinics (the Spanish Catholic Center, La Clinica del Pueblo and the Mary's Center for Maternal and Child Health) specialize in the care of Hispanic patients. The Washington Free Clinic has traditionally served patients from the African subcontinent. With the projected increase, in the ethnic immigrant population, noted by the Washington Council of Governments (COG), the need for cultural competence will grow.

6. Reimbursement Gaps

Reimbursement gaps may exist for primary care services that are crucial to target populations of at-risk and chronically ill patients. Medicaid expansions, combined with the Department of Health's Immigrant Children insurance program, have ensured near-universal eligibility for children under 200 percent of federal poverty level. However, primary care reimbursement rates are low under Medicaid managed care programs and may not support the full cost of caring for high-risk patients in a clinic setting.

Most of the care of persons with HIV and AIDS is currently supported by federal and local funds under the federal Ryan White Care Act, and may in the future be covered by Medicaid under a new waiver.

The primary care safety net still depends heavily on maintenance of effort by non-profit providers. These providers, in turn, mainly depend upon their revenue on special project grants, foundations and on individual donations. These funding streams are not secure. An economic downturn may lead to reduced charitable giving and could have a serious impact on the District of Columbia's safety net.

IV. SUMMARY RESOURCE INVENTORY AND HISTORICAL UTILIZATION

During the District's fiscal year 2003, a comprehensive inventory of primary care clinics will be developed and available.

Primary Care Providers

In summary, the District of Columbia's primary care providers and safety net providers currently consists of:

1. The Archdiocesan Health Care Network operated by Catholic Charities;

2. Hospital-affiliated clinics;
3. Private physicians, nurse practitioners and group practices/clinics;
4. Medicaid-only clinics;
5. Health Maintenance Organization-affiliated outpatient clinics, and;
6. Preferred Provider Organizations (PPOs).

Primary and specialty care resources readily available throughout the District of Columbia to patients with the ability to pay for these services. One study reports and compares key ratios of providers to population as shown below in Table 1. An inventory of actively practicing health care professionals is available through the District of Columbia's Professional Licensing Boards and from associations that represent different categories of health professionals.

Table 1.

D.C. The Comparison of District of Columbia and National Primary and Specialty Care Resources – 1998

Resource	D.C.	U.S.
Physicians per 100,000 population		
Generalists	189	81
Specialists	342	128
Physician Assistants per 100,000	31.5	9.8
Nurse Practitioners per 100,000	94.9	48.4
Social Workers per 100,000	289.6	216.0
Dieticians & Nutritionists per 100,000	230	16.6
Population Underserved by		
Primary Care Physicians	25.4%	9.5%
Dentists	2.4%	4.2%

Source: Ormond, B.A. and Bovberg, R.R. *The Changing Hospital Sector in Washington, D.C.: Implications for the Poor*. Washington, D.C.: The Urban Institute, 1998. Government of the District of Columbia, Department of Health, Health Professional Licensing Administration, Bureau of Labor Statistics, Division for Nursing.

The study cited in Table 1 reveals disparities in the distribution of health care resources in the District of Columbia. There are more than twice as many generalists and almost three times as many specialists per 100,000 population in the District compared to the U.S. as a whole. Yet, at the same time, there are more than twice as many people

underserved by primary care physicians (25.4 percent for D.C. vs. 9.5 percent for the U.S.).

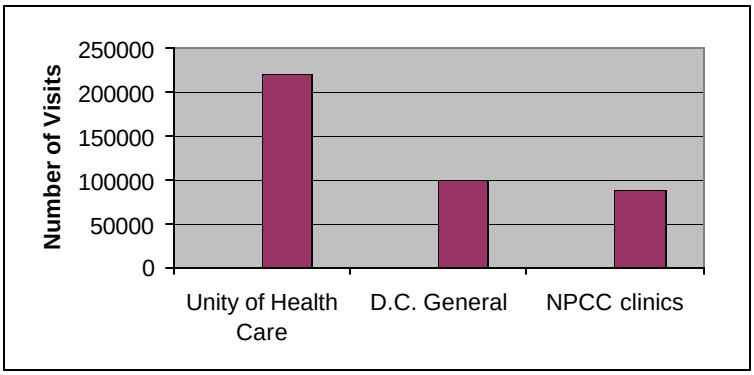
The abundance of physicians is at least in part due to the presence of three academic medical centers in the city (George Washington University Hospital, Georgetown University Hospital and Howard University Hospital), as well as a major teaching hospital (Washington Hospital Center). These resources are clustered in the wealthier parts of the city, particularly in Northwest, D.C. Most of the private clinics are also located in the same area. Table 2 lists District clinics and their locations by ward and Figure 1 shows the utilization of the public clinics by the medically vulnerable population.

Table 2. District of Columbia Health Clinics by Ward, 2000

WARD	NUMBER OF PUBLIC CLINICS	NUMBER OF PRIVATE CLINICS	TOTAL
One	1	10	11
Two	2	13	15
Three	1	2	3
Four	0	2	2
Five	2	1	3
Six	3	2	5
Seven	2	4	6
Eight	1	1	2
TOTAL	**12**	**35**	**47**

Source: DCPCA, 2001

Figure 1. Medically Vulnerable Primary Care Visits by Location, 2000



Due to the uniqueness of the District as the nation's capital and as the location of many federal office buildings, the vast number of commuters and visitors, and diplomatic personnel significantly increases the number of people that are in the city daily. This number of individuals is estimated to be over 700,000. In drawing the conclusion about the abundance of health professionals in the District, this number of non-residents distorts the health professional percentages and the provider to population ratios.

Occupational Patterns of Primary care Providers in the District

After hospitals, the second most popular work site for health service workers in the District was in physician offices and clinics, comprising a mixture of private and public employers. Labor statistics for the District in 1998 showed the 5,412 or 14.1 percent of the health services sector employees were working for clinic offices and physicians. Approximately 3,466 individuals worked in physician offices or clinics, 1,234 people worked in dentist offices or clinics, and 732 worked in other types of health service-related offices or clinics. The proportion of office and clinic workers per 100,000 population was comparable to regional and national figures. The overall percentage health service workers employed in this sector reflects the concentration of hospitals in the city as a major metropolitan health center. Table 3 summarizes the mix of clinic and physician office employment locally, regionally, and nationally.

The 493 advanced practice nurses working in the District comprise 94.5 nurse practitioners per 100,000 population, nearly three times the national average of 26.3. There were 35 certified nurse midwives in the year 2000, comprising 3.8 per 100,000 population, well above the national average of 2.1. The 43 certified nurse anesthetists are comparable to the national average of 8.6 per 100,000 population.

Table 3. Employment in Physician, Dental and other Health-related Offices and Clinics, 1998

	DISTRICT OF COLUMBIA	REGION III	U.S.
Employment in physician offices and clinics	5,412	301,752	2,964,043
Employment in physician offices and clinics per 100,000 population	1,038	1,118	1,097
Percent of health services employment in physician offices and clinics	14.1%	26.5%	26.6%

V. POPULATION GROWTH AND PRIMARY CARE SERVICES

A. Growth in the District's Population

According the District's Office of Planning, the population is expected to grow by 21,800 during the period 2005 to 2010. The primary health care system in the District has to factor this population increase when planning health services.

1. Population growth may increase demand in primary care services.

Beginning in the late 1990's the population began to decline in the District of Columbia. The population is now growing. Table 3 shows the total population forecast for 2005 and 2010.

Table 3. District of Columbia Population Growth	
US Census 2000	572,059
Projected 2005	593,800
Projected 2010	615,600
US Census 2000 actual count from published data and the District of Columbia Office of Planning	

B. Demand for Primary Care Services

The National Ambulatory Care Medical Survey (NAMCS) conducted by the Centers for Disease Control (CDC) (National Center for Health Statistics, 2001), provides utilization rates for primary and specialty care services for the U.S. as a whole. These vary by race and age, as shown in Table 4. According to the NAMCS, which is conducted annually, there was little change in the overall utilization rates between 1992 and 1997.

Table 4. Outpatient Visits Per 100 Persons in 1997.

	Physician Offices	Hospital Outpatient & Emergency Depts.
Age		
Under 15 years	230.1	65.3
15-24 years	170.0	63.0
25-44 years	244.5	60.1
45-64 years	351.0	60.7
65-74 years	551.8	61.3
75 years and older	652.6	97.0

TOTAL	**2200**	**407.4**
Sex		
Male	242.6	58.0
Female	345.3	70.6
TOTAL	**587.9**	**128.6**
Race		
Black	228.2	114.0
White	309.6	68.3
Asian/Pacific Islander	90.3	11.0
Hispanic/Latino	80.9	11.2
American Indian/Alaska Native	53.9	14.8
TOTAL	**762.9**	**219.3**

SOURCE: National Center for Health Statistics (November 1999). Ambulatory Care Visits to Physician Offices, Hospital Outpatient Departments, and Emergency Departments: United States, 1997.

Nationally, there were an estimated 959.3 million ambulatory care visits made to physician offices, hospital outpatient departments, and hospital emergency departments in 1997, an overall rate of 360 visits per 100 persons. Visits to office-based physicians were predominant, accounting for 82.1 percent of combined ambulatory care utilization.

A mal-distribution of primary and specialty care providers that staff primary care clinics may exist in underserved areas. However, the inventory of primary and specialty care providers in the District is more than adequate to meet the demand.

Nationally and in the District of Columbia, African Americans have higher morbidity and mortality rates due to many chronic conditions, including heart disease and cancer. It is reasonable to hypothesize that greater use of primary and preventive care, as well as other lifestyle changes will reduce the burden of chronic disease among African Americans. The result of these changes may lead to reduced emergency room utilization and improved morbidity and mortality. The same argument holds for other ethnic underserved groups with poor health status.

Through the creation of attractive, culturally sensitive primary care sites that deliver quality care, the District of Columbia may increase demand for primary care. At the same time decreasing the utilization of costly emergency care.

According to an AARP study (Reforming the Health Care System: State Profiles 2001), a need exists for more geriatric primary care clinics in underserved areas in the District of Columbia.

VI. CRITERIA AND STANDARDS

The State Health Planning and Development Agency (SHPDA) uses six criteria, outlined in the State Health Systems Plan, to assess the performance of each aspect of the District of Columbia's health care service delivery system: availability, accessibility, continuity, quality, acceptability and cost. Some health care service providers may be required to obtain a Certificate of Need (CON) for new or expanded services.

A. Availability

Availability is defined as the need projection indicating the supply of resources in relation to the need or the demand for resources. The availability of primary care services include:

1. Hours of operation convenient for the patient;
2. Availability of appointments within two weeks of request;
3. On-site integration of services;
4. Availability of enabling and support services – transportation, language interpretation and outreach, and;
5. Referral to appropriate specialty care as a part of continuity of care

Providers must also have a mechanism, such as an on-call physician or a staffed advice line, which allows patients to obtain urgent medical advice during hours when the office is closed.

B. Accessibility

Accessibility is the measure of the ease of entry of services for the consumer.
Ease of entry includes:

1. Affordability of services;
2. Location of services, and;
3. Travel distance

The Department of Health's standards of care for primary care services incorporates requirements for certified clinics to treat all patients who present for care without regard to that person's income and offer a sliding fee scale based on income. Uninsured patients whose income is below one hundred percent (100%) of the federal poverty level would either not pay or pay a nominal fee. Additionally, the standards address the patient population to ensure that District of Columbia residents whose family income is 200

percent of the federal poverty level have access to primary healthcare. The standards also state that the organization's patient base must include at least one-third of the low-income population.

One of the concepts of medical homes implies that the location of the service provided by within an easily accessible distance from where the patient resides.

C. Continuity

Continuity is the structure, coordination and delivery of services on a continuous basis and in a timely manner. Continuity of care includes:

1. Plan of care based on the knowledge of the patient's medical history;
2. Knowledge of accessing appropriate level of care when needed;
3. Receiving care in a timely manner, and;
4. Providing appropriate referrals and follow-up

Primary healthcare facilities must be capable of serving as the patient's medical home. A medical home is a setting, where an individual receives care by an assigned provider, who has the obligation to ensure that continuity and quality of care is delivered in a nurturing and culturally sensitive environment. The medical home helps to promote the development of a nurturing relationship between the patient and the provider.

The facility should also have the ability to provide continuity of care through an integrated referral system that included arrangements for follow-up for in-patient and specialty care (i.e. home health services, rehabilitative services, mental health services, dental services, vision services, pharmaceutical services, health education services, language interpretation, therapeutic services, in-patient hospital services and medical specialist).

D. Quality

Quality is defined as the degree of excellence characterized by levels of technical competence, appropriateness, safety and beneficial impact. Quality of care includes:

1. Patient perception of the care received;
2. Appropriate professional credentialing of health care providers;
3. Conducive environment;
4. Culturally-competent staff;
5. Accreditation by a relevant professional organization, and;
6. Professional practice standards

Furthermore, the plan shall include a methodology for reviewing the entire range of care provided by the facility. Organizations seeking certification from the District of Columbia will be required to submit a written continuous quality improvement plan that

includes measurable objectives and a timetable for implementation. The plan will address the quality of both clinical care and non-clinical services including availability of care, accessibility of the facility, coordination of care and continuity of care.

Certified primary care facilities will provide healthcare under the direction of a medical director who is a licensed medical practitioner in the District of Columbia. The medical director must have the authority to direct the clinical staff, to hire and remove staff, to implement the Continuous Quality Improvement Plan and to establish health maintenance schedules and practice guidelines.

E. Acceptability

Acceptability is defined as the degree of satisfaction of the services to the community and its users. Acceptability includes:

1. Convenience to the user;
2. Positive provider attitudes;
3. Equity in services;
4. Problem resolution, and;
5. Institutional respect for cultural and religious differences

Acceptability is important in providing opportunities to determine the level of satisfaction experienced by the consumers.

F. Cost

Cost is defined as the total expenses and economic consequence of the provision of services, including provider cost, consumer cost, opportunity costs and societal costs. Costs include:

1. Minimal or no fee for services to the underserved residents
2. Posted schedule of discounted or waived fees
3. Pharmaceutical discounts, i.e. generic medications where appropriate

Clinics would be required to demonstrate their ability to provide uncompensated care to medically vulnerable populations and have a written policy.

VII. GOALS AND OBJECTIVES

Goal 1:

Increase access to primary and ambulatory care services to District of Columbia residents in areas where needed, by ensuring equitable distribution of primary care facilities in all Wards.

Objectives:

1.1 Apply to the U.S. Department of Health and Human Services, Bureau of Primary Health Care and other organizations for funding to increase the number health safety net facilities in the Health Professional Shortage Area (HPSA) areas.

1.2 Work with other entities to secure capital for the improvement of physical infrastructure of safety net clinics.

1.3 Work with medical schools and professional medical societies to increase the number of private health care providers who work in clinics located in underserved areas.

1.4 Work collaboratively with providers and the National Health Services Corps (NHSC) to develop slots in which scholars and loan repayment practitioners may be placed.

1.5 Develop a comprehensive inventory of primary and ambulatory care clinics to publish a directory.

Goal 2:

Develop and implement an action plan to improve quality of primary care service delivery that will strengthen the role of the DOH in the provision, and oversight of disease prevention and primary care in the District of Columbia.

Objectives:

2.1 Collaborate with other local and regional provider organizations to establish uniform standards and determine baseline indicators of quality of care.

2.2 Measure and benchmark outcomes and performance-based quality indicators.

2.3 Publish studies that support the implementation of the quality indicators.

Goal 3:

Vertically and horizontally integrate the data from the primary care clinics into the health care system.

Objectives:

3.1 Utilize data from the Computerized Medical Records Demonstration Project.

3.2 Define charity care standards for hospitals and incorporate them into the Certificate of Need and licensing processes, to ensure that those who remain uninsured have access to affordable care.

3.3 Establish minimum standards of coordination of referrals of patients between primary care providers and specialty care providers to achieve total integration.

Goal 4:

Identify funding sources for capitalizing ambulatory care facilities that demonstrate a willingness and ability to re-engineer.

Objectives:

4.1 Provide technical assistance to clinics to obtain DCQHC status thereby increasing their funding opportunities.

4.2 Increase the number of local safety net facilities that qualify for FQHC or look-alike funding.

Goal 5:

Ensure that all programs developed are culturally competent and meet the needs of the community, patient and family.

Objectives:

5.1 Develop specific standards to measure the effectiveness of the program in meeting the needs of the community at the primary care sites.

5.2 Collaborate with the Area Health Education Center (AHEC) to ensure that an adequate pool of qualified, culturally competent providers is available from which to recruit and to assist in the establishment of a referral network of culturally competent providers, with varied language capabilities.

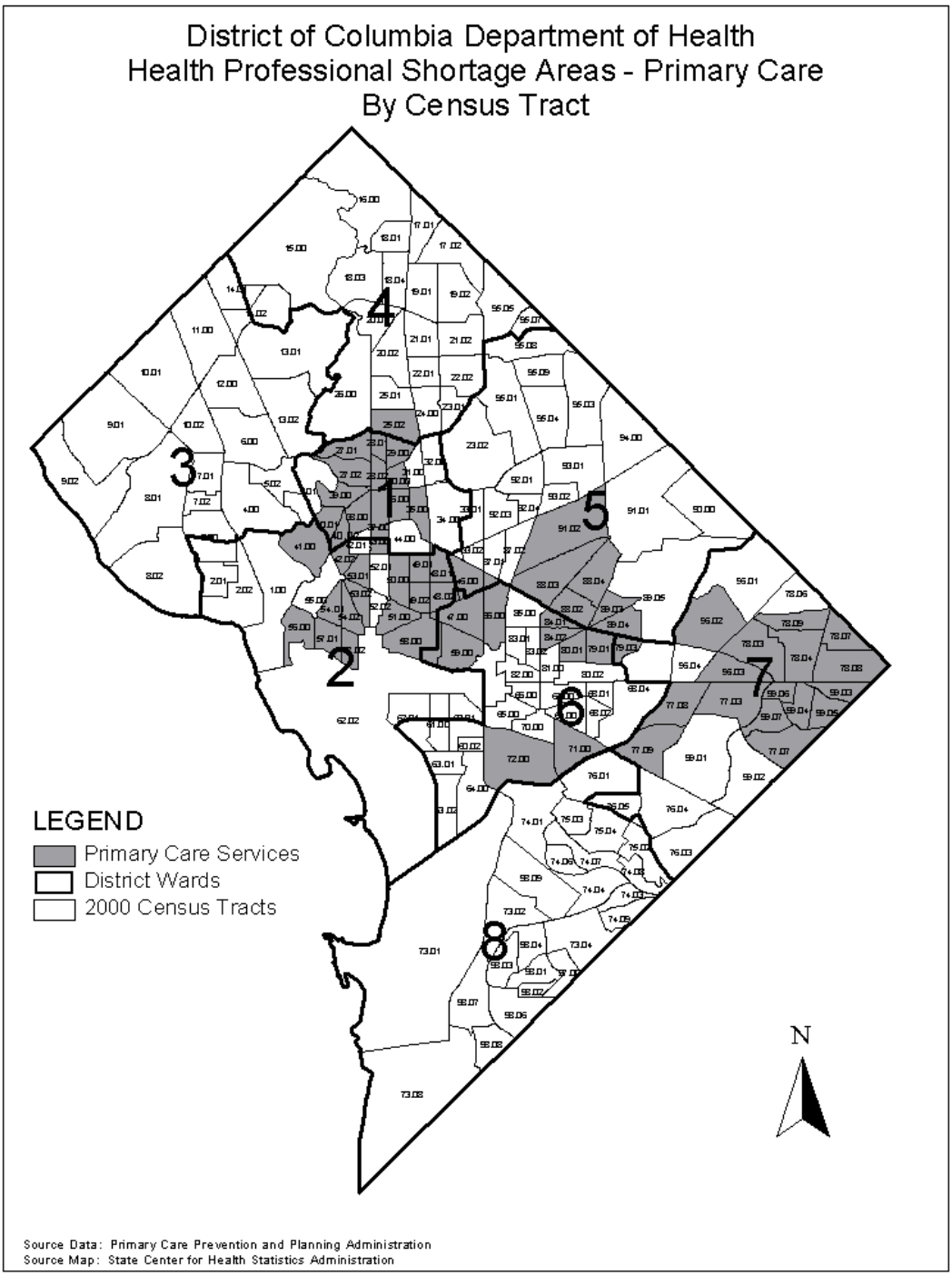
Goal 6:

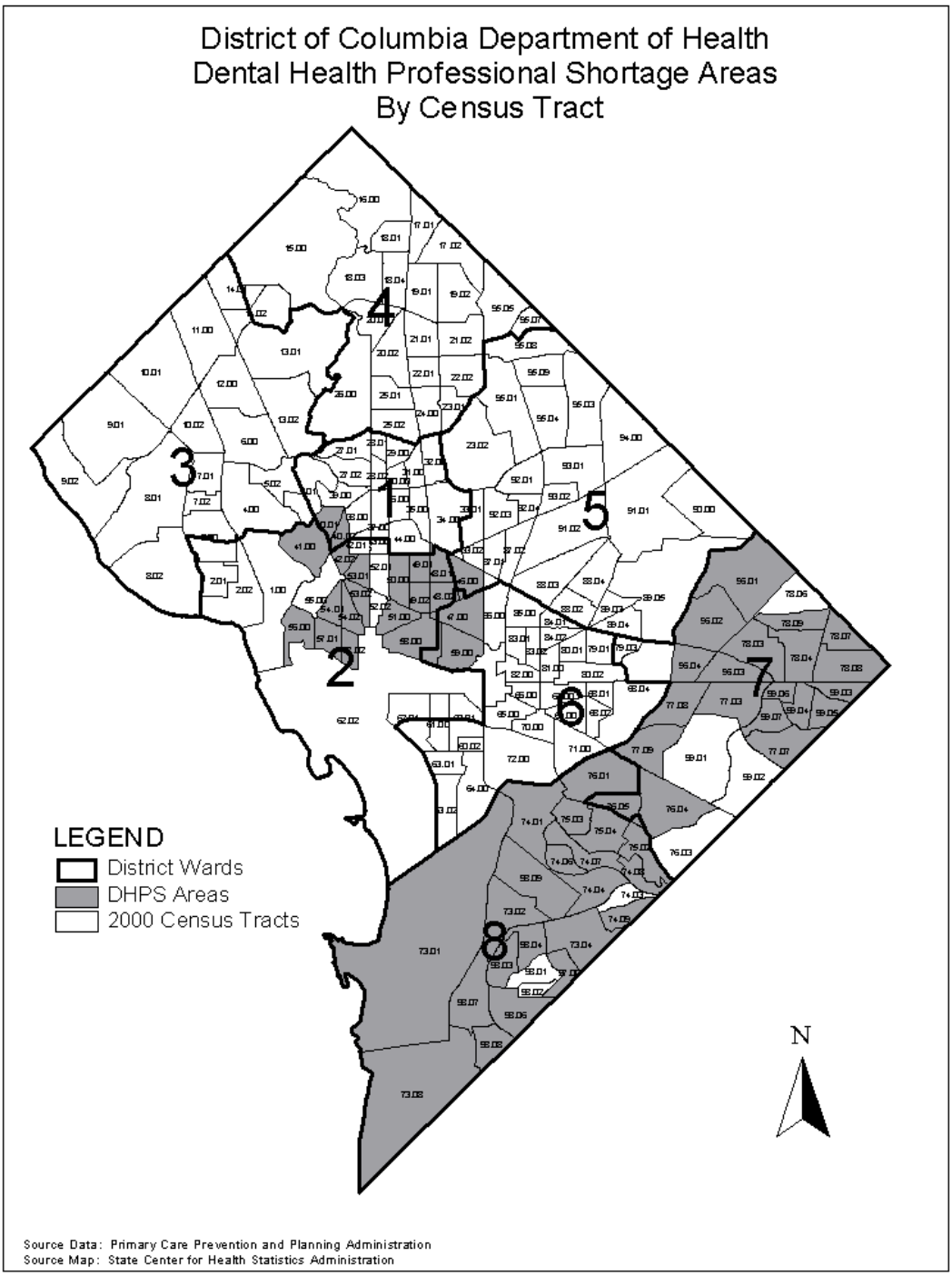
Develop additional geriatric primary care clinic sites.

Objectives:

6.1 Collaborate with the D.C. Office on Aging and private agencies within the District of Columbia to conduct a study to determine the primary care needs of the elderly.

6.2 Identity quality standards that address the primary care needs of the elderly population.


District of Columbia Department of Health
Health Professional Shortage Areas - Primary Care
By Census Tract
LEGEND
Primary Care Services
District Wards
2000 Census Tracts
N
Source Data: Primary Care Prevention and Planning Administration
Source Map: State Center for Health Statistics Administration


District of Columbia Department of Health
Dental Health Professional Shortage Areas
By Census Tract
LEGEND
District Wards
DHPS Areas
2000 Census Tracts
1
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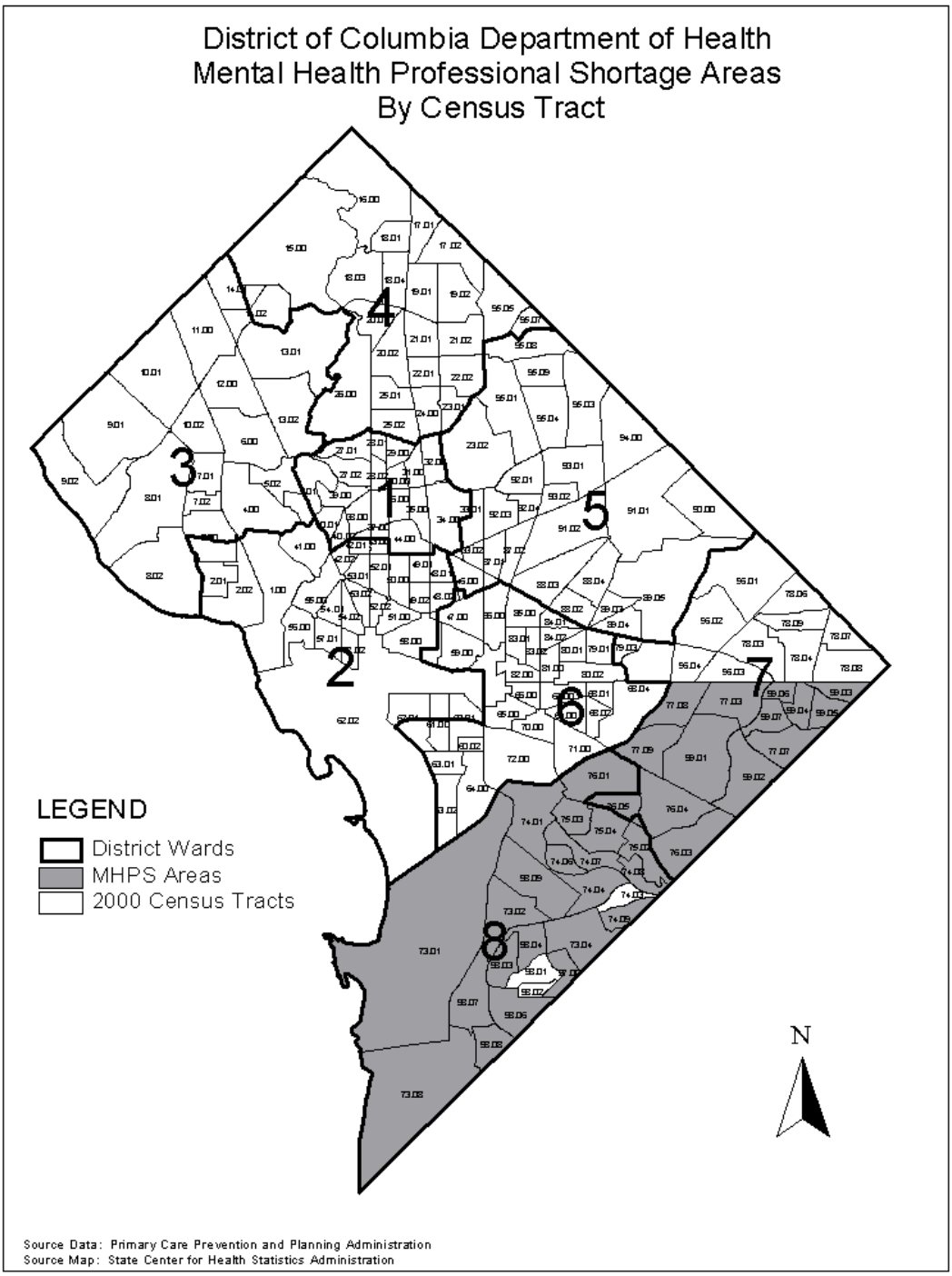
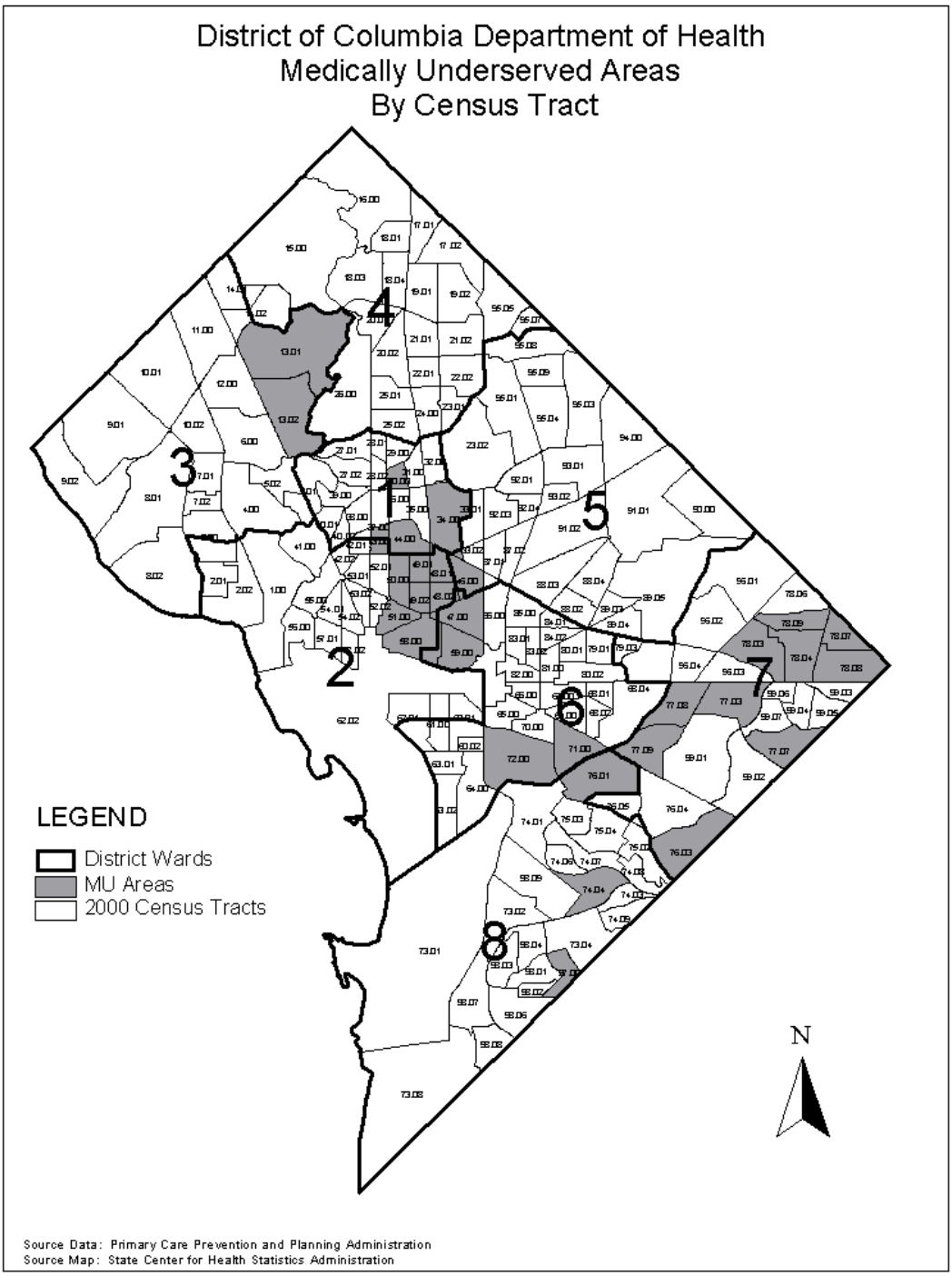
Source Data: Primary Care Prevention and Planning Administration
Source Map: State Center for Health Statistics Administration


District of Columbia Department of Health
Mental Health Professional Shortage Areas
By Census Tract
LEGEND
District Wards
MHPS Areas
2000 Census Tracts
N
Source Data: Primary Care Prevention and Planning Administration
Source Map: State Center for Health Statistics Administration


District of Columbia Department of Health
Medically Underserved Areas
By Census Tract
LEGEND
District Wards
MU Areas
2000 Census Tracts
N
Source Data: Primary Care Prevention and Planning Administration
Source Map: State Center for Health Statistics Administration